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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Updated WHO guidance on safe abortion: Health and human rights

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ABSTRACT

Since its first publication in 2003, the World Health Organization's "Safe abortion: technical and policy guidance for health systems" has had an influence on abortion policy, law, and practice worldwide. To reflect significant developments in the clinical, service delivery, and human rights aspects of abortion care, the Guidance was updated in 2012. This article reviews select recommendations of the updated Guidance, highlighting 3 key themes that run throughout its chapters: evidence-based practice and assessment, human rights standards, and a pragmatic orientation to safe and accessible abortion care. These themes not only connect the chapters into a coherent whole. They reflect the research and advocacy efforts of a growing field in women's health and human rights.

1. Introduction

In June 2012, the World Health Organization (WHO) issued an update of its "Safe abortion: technical and policy guidance for health systems" [1]. First published in 2003, the Guidance was the only publication of its kind, offering global recommendations on clinical, service-delivery, as well as legal and policy aspects, of safe abortion. Since then, having been translated into French, Russian, and Spanish among other languages, the Guidance has been used as a tool in strategic assessments conducted by ministries of health in 12 countries including Mongolia [2], Macedonia [3], and Malawi [4], and in other national efforts to improve the quality of and access to abortion care. In 2006, for example, following the liberalization of the abortion law in Colombia, the Guidance served as a template for national technical norms on legal abortion services [5]. When the 2006 norms were subsequently challenged as unlawful and suspended, the Guidance was proposed as a stopgap measure to ensure continuity of care.

Since the first edition, there have been significant developments in the clinical, service delivery, and human rights aspects of safe abortion. The substantial revisions in the updated Guidance reflect these changes, particularly in methods of abortion, decentralization and expansion of service delivery, and in application of human rights in policy making and legislative reform.

This article seeks to elaborate 3 key themes that unite these changes across the Guidance. These themes are: affirming an evidence-based approach, strengthening human rights standards, and reflecting a pragmatic orientation to safe and accessible abortion care.

First, the Guidance reflects an increasing emphasis that policy, law, and practice should be based on the best available evidence, accounting for the characteristics, needs, and preferences of the women seeking care. Recommended interventions are those shown to have a positive impact on health outcomes, including reduced abortion-related morbidity and mortality. The Guidance also cautions against barriers that impede access to safe abortion care without evidence of health benefit or other justification.

Second, the Guidance is firmly grounded in international human rights treaties, and references a growing body of human rights standards on safe abortion. These standards are authoritative interpretations and applications of human rights in the context of abortion by international and regional human rights bodies and national courts, including the United Nations treaty monitoring bodies. The Guidance cites examples of human rights standards on maternal mortality due to unsafe abortion, the decriminalization of abortion, and the elimination of regulatory and administrative barriers that impede women's access to lawful services [1] (Box 4.1, p.88–89).

Third, the Guidance follows the aphorism, "Let not the best be the enemy of the good." It recognizes that safe abortions, if inaccessible, do little to redress the problem of unsafe abortion. The Guidance thus sensibly calibrates accessibility and quality of care as co-determinants of safe abortion. It pragmatically acknowledges that a single gold standard of abortion care is unrealistic in a guidance of global reach, and so offers recommendations responsive to different settings, including low-resource. Consider recommendations on medical methods of abortion. The Guidance notes that the most effective regimens rely on a combination of mifepristone and misoprostol [1] (p.42), but

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offers recommendations for misoprostol-alone regimens where mifepristone is unavailable [1] (pp.45–46).

These themes are elaborated below by reference to select recommendations in the clinical, service-delivery, and legal and policy chapters of the updated Guidance. These recommendations are intended to be merely exemplary. The Guidance offers many more recommendations critical to ensuring safe and accessible abortion care.

2. Clinical care for women undergoing abortion

Chapter 2 addresses the clinical management of abortion, and is accompanied by a companion document: "Clinical practice handbook for safe abortion care" [6].

The clinical recommendations reflect a strong emphasis on evidence-based medicine [7], but not to the exclusion of human rights considerations. Rather, the Guidance shows how these approaches can reinforce one another. Consider the strong recommendation against dilation and sharp curettage (D&C), referred to as an "obsolete method of surgical abortion" that "should be replaced by vacuum aspiration" [1] (p.31). This recommendation is based on evidence of relative safety [8]. It is also informed, however, by evidence that D&C is considerably more painful for women, and thus by considerations of improving not only safety but also quality of care [1] (p.41). Attention to the experience of abortion, and especially to protecting against unnecessary pain or needless discomfort, respects the human rights of women, especially as set against an historic and in some places current punitive practice of denying women anesthesia during care [9]. To this end, the Guidance recommends "pain management… should always be offered, and provided without delay to women who desire it" [1] (p.39).

While Chapter 2 does not expressly cite human rights standards, many of its clinical recommendations reflect them. Consider recommendations on pre-abortion information and counseling. Free and informed decision making is recognized to be an essential part of good quality abortion care. Chapter 2 states that "[i]nformation must be provided to each woman…in a way that she can understand, to allow her to make her own decisions about whether to have an abortion and…by what method", and that "[m]any women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counseling" [1] (p.36). Chapter 4 links these recommendations to human rights standards of access to information, respect for dignity, and sensitivity to a woman's needs and perspectives [1] (p.97). Women have a right to be fully informed of their options for health care, such that the Guidance reminds states of their human rights obligations to refrain from and to protect against censorship, withholding, or intentional misrepresentation of information about abortion services. Recommendations on contraceptive information and counseling, as well as the initiation of contraception in the context of abortion care, likewise reflect not only evidence-based standards, but the human rights standard of freedom from coercion [1] (p.18), by noting that "[a] woman's acceptance of a contraceptive method must never be a precondition for providing her with an abortion" [1] (p.37).

That the updated Guidance does not set upper gestational limits on safe abortion methods is an important change. The 2003 Guidance summarized methods of abortion most appropriate at different stages of pregnancy, ending the summary at 22 weeks gestation [10]. This was misinterpreted to wrongly suggest that a safe abortion could not be provided beyond 22 weeks, and that gestational prohibitions were thereby justified on grounds of safety. The updated Guidance, in contrast, states only that the "most appropriate methods of abortion differ by the duration of pregnancy" [1] (p.37) and offers recommendations for pregnancies beyond 24 weeks [1] (pp.115–116). While safety is affected by the gestational age at the time of the abortion [11], the expansion of first trimester services can never eliminate the need for safe abortion later in pregnancy [12]. The reasons why women present for abortion at later gestations are many, including service delivery barriers that delay care [13]. Women entitled to a legal abortion should have access to the procedure as soon as possible, but ensuring access to safe and legal abortion later in pregnancy is also critical to the health and lives of women, especially the most vulnerable women, the poorest and the youngest, disproportionately represented among late seekers [14]. The Guidance thus describes gestational prohibitions as a barrier to care that create social inequities [1] (p.93).

3. Planning and managing safe abortion care

Chapter 3 addresses the service delivery context with the primary recommendation that "safe abortion services should be readily available and affordable to all women" [1] (p.8). The chapter focuses on factors necessary not only for clinical safety, but to ensure that all women can access the safe abortion care to which they are legally entitled. Good quality and equitable access are dual objectives of health system regulation [1] (p.65).

Reflecting this orientation, the Guidance emphasizes the simplifying, or streamlining of abortion care, even noting a high value on research to demedicalize abortion care [1] (p.2). Chapter 3 specifically identifies policies and practices that restrict women's access without justification. It stresses in equal measure what is *not* necessary, what is *not* required, to ensure safe abortion care, as much as what is required. A historical perspective shows the importance of such guidance. For too long the provision of and access to abortion care was, and remains in many places today, burdened by regulation that reflects not evidence-based practice, but ideological opposition. These regulatory barriers, however, are often justified in the name of health protection, but rarely with any *evidence* of health-related need or benefit. In the USA, the apronym, TRAP, short for the "targeted regulation of abortion providers (and facilities)," suggests the specious intention of such regulation [15]. The Guidance counsels that "certification and licensing of services should be the same as for other medical procedures and should not be a barrier to the availability and provision of abortion care…[Regulation] should not impose excessive requirements for infrastructure, equipment, or staff that are not essential to the provision of safe services" [1] (p.67). Rather the regulation of abortion services "should be evidence-based to protect against over-medicalized, arbitrary or otherwise unreasonable requirements…regulation should be based on criteria required for provision of safe abortion care" [1] (p.96).

Consider requirements for introducing medical methods of abortion into health systems, an integration that should be expanding with mifepristone and misoprostol now on the WHO Model List of Essential Medicines [16]. Both vacuum aspiration and medical abortion, the Guidance explains, "can be provided at the primary-care level on an outpatient basis and do not require advanced technical knowledge or skills, expensive equipment such as ultrasound, or a full complement of hospital staff (e.g. an anaesthesiologist)" [1] (p.67). Primary-level delivery is "safe, and minimizes costs while maximizing the convenience and timeliness of care for women" [1] (p.65), given that most of the equipment, medications, and supplies needed for both methods are the same as those needed for other gynecological services [1] (p.71).

That medical abortion can be provided at the primary-care level should not be read, however, as a requirement that it must. Early in 2011, a UK legal challenge to allow for home use of misoprostol failed, but the High Court ruled that the Department of Health could amend the rules for service delivery if advances in medicine justified it [17]. The Guidance affirms that home use of misoprostol is a safe option for women [1] (p.44), and further acknowledges that "[a]llowing home use of misoprostol following provision of mifepristone at a health-care facility can further improve the privacy, convenience and acceptability of services, without compromising on safety" [1] (p.65).

The Guidance even suggests the evaluation of internet provision and telemedicine, as further alternative service delivery channels of safe abortion, as a subject for future research [1] (p.105).

To facilitate access to care, the Guidance also emphasizes differentiation in regulation to reflect different requirements for safe abortion among different methods, facilities, and providers [1] (p.67). A key example is competency-based training in the licensing of providers [1] (p.63). This term implies that providers must only be trained to the level of competence required for the tasks they undertake. Competency-based training asks: What knowledge and skills are required to safely provide this abortion method? To the extent that abortion methods differ in the knowledge and skills required for their safe provision, the Guidance envisions the training and thus licensing of a range of healthcare providers to safely administer and supervise abortion care, including midlevel (i.e. non-physician) providers [1] (pp.65,72). The support for midlevel providers is evidence-based. The Guidance cites comparative studies showing no difference in complication rates between first-trimester abortions provided by midlevel providers and physicians [18]. More importantly, however, support for midlevel providers reflects the reality that in many contexts, making safe, legal abortion services accessible to all women depends upon them.

The Guidance is not indifferent to the ends that service delivery regulation serves. It does not merely require that policies and practices directed to whatever end be evidence-based. It identifies explicitly an end result to which laws and services should be directed: the protection and promotion of the health and human rights of women.

The Guidance overall reflects a renewed focus on women as more than users of services or patients of health providers. Women are treated as rights bearers within the health system, entitled not merely to access safe and legal abortion services, but to do so "in a way that respects a woman's dignity, guarantees her right to privacy and is sensitive to her needs and perspectives" [1] (p.64). Privacy protections, for example, a private place to undress, curtained windows, and cloth or paper draping during procedures, are guaranteed not merely because their absence may deter women from seeking care, but in respect of a woman's right to privacy, to ensure her comfort and ease [1] (p.69). Reflecting the same approach, the Guidance recognizes that "[r]espect for a woman's choice among different safe and effective methods of abortion is an important value in health-service delivery" [1] (p.67). In this way, health systems are regarded as "not only producers of health or health care but…purveyors of a wider set of societal values and norms" [19]. The Guidance seeks to imbue the delivery of abortion services with values of respect, worth, and dignity. "Abortion services should be integrated into the health system…to acknowledge their status as legitimate health services and to protect against stigmatization and discrimination of women and health-care providers" [1] (p.64).

4. Legal and policy considerations

Chapter 4 addresses legal and policy considerations, and "highlights the inextricable link between women's health and human rights and the need for laws and policies that promote and protect both" [1] (p.87). It uses both evidence-based and human rights standards to recommend significant change in the regulation of abortion.

The Guidance favors an evidence-based assessment of abortion laws, that is, it looks to the evidence of the actual rather than intended effect of the law. It finds that legal restrictions on abortion do not result in fewer abortions, nor do laws that facilitate access increase the rate or numbers of abortion [1] (p.90). Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion remains the same [1] (p.23). Legal status does make a difference, however, to the safety of abortion. The Guidance cites overwhelming evidence of association between legal restrictions and higher numbers of unsafe abortions and related mortality. In contrast, where safe abortion services are legally available on broad social grounds or on a woman's request, the incidence of and mortality from unsafe abortion can be reduced to a minimum [1] (p.90).

This evidence-based rationale for legal reform is complemented by human rights standards that recommend the decriminalization of medical services needed only by women [1] (p.89), and minimum legal grounds for abortion, including threats to the pregnant woman's life or health, and where pregnancy results from rape or incest [1] (p.92). The Guidance thus no longer starts from the baseline that "in circumstances where abortion is not against the law" such abortion must be safe and accessible. It recognizes that the law itself may require reform as a matter of evidence-based policy and human rights obligations [1] (p.88).

The Guidance further acknowledges that human rights standards apply not only to the enactment of legal grounds, but also to their interpretation. Women are often wrongly denied services to which they are lawfully entitled because service providers and facility administrators interpret legal grounds in an unduly restrictive manner [20]. The Guidance thus provides important recommendations on the broad scope of legal grounds. It advises, for example, that where laws permit abortion to protect health, this permission can extend to the full WHO constitutional description of health: "a state of complete physical, mental and social well-being." Grounds for fetal impairment or rape, where not explicit in the law, may likewise constitute a threat to the woman's health by reference to the mental distress they may cause [1] (p.92). The Guidance not only sets forth broad interpretations, it also elaborates human rights obligations on governments to establish "[i]nstitutional and administrative mechanisms…[to] protect against unduly restrictive interpretations of legal grounds" [1] (p.98). In this respect, the Guidance follows a growing body of human rights jurisprudence on accountability in the administration of legal grounds, recognizing the rights of women to participate in the decision-making process, and to the timely appeal and review of denials of legal care [21].

Health system and service delivery barriers are also often codified in law and regulation, which significantly restrict access and are thus also subject to evidence-based assessment and human rights standards. These barriers include restrictions on access to information, the over-regulation of facilities, providers, and methods of abortion, and the under-regulation of privacy and the exercise of conscience objection, among others [1] (p.94).

A human rights rationale for eliminating these legal and regulatory barriers often resides in their impeding women's access to safe abortion care. Evidence-based assessment shows the many ways these barriers deter, delay, and increase the costs for women seeking care [1] (p.94). These barriers violate human rights because they jeopardize women's access to safe, legal abortion care, and therefore jeopardize women's health. The Guidance notes, for example, that health providers' exercise of conscientious objection without any enforced requirement of referral to a willing and trained provider, can delay if not deny care for women in need of safe abortion, increasing risks to their health and lives [1] (p.96).

The strong human rights orientation of the Guidance can, however, perhaps best be seen in its attention to service delivery regulation that violates women's human rights for reason more than jeopardy to health. The Guidance, for example, recognizes that third-party authorization requirements, including hospital approval committees and police reporting, violate human rights of equality and non-discrimination not simply because they deter and delay access, but because they do so disproportionately for vulnerable and marginalized women [1] (p.95). Safe abortions "become the privilege of the rich, while poor women have little choice but to resort to unsafe providers" [1] (p.1). The injustice of such regulation is not simply denied access, but inequitable access. Third-party authorization further violates human rights by interfering with "women's and adolescents' right to make decisions about reproduction and to exercise control over their

bodies" [1] (p.89). Like mandatory counseling policies and waiting periods, authorization requirements demean women as competent decision makers [1] (p.96).

5. Conclusion

The interwoven themes of evidence-based practice and assessment, human rights standards, and a pragmatic orientation to safe and accessible care not only unite the various parts of the Guidance into a coherent whole. They reflect the profound nature of change in this field. The Guidance is the product of an extensive review of voluminous new research on the epidemiological, clinical, service delivery, legal, and human rights aspects of abortion, and of meaningful engagement with a diverse set of global stakeholders, including health service providers, health program managers, researchers, methodologists, human rights lawyers, and women's health advocates. The Guidance, in other words, has benefitted enormously from the dedicated efforts of a growing field in women's health and human rights. The task now is to turn knowledge into practice, for the Guidance to guide, and to effect real change in women's access to safe abortion.

Conflict of interest

Joanna N. Erdman and Teresa DePiñeres were members of the guidelines development group and served as participants in the Technical Consultation to review the draft recommendation and the supporting evidence of the Updated Guidance. Joanna N. Erdman also directed research work to assist in the revision of the Guidance under the International Reproductive and Sexual Health Law Program in the Faculty of Law in the Faculty of Law at the University of Toronto, Toronto, Canada. Eszter Kismödi formerly served as a Human Rights Adviser in the Department of Reproductive Health and Research, WHO, Geneva, Switzerland, and participated in the Guidance update in this capacity.

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